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COST-BENEFIT ANALYSIS OF OBSTETRICAL/GYNECOLOGICAL PHYSICIANS WHO ACCEPT ACTIVE DUTY PATIENTS ON THE MONTEREY PENINSULA

by

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With major shifts in military health care, more active duty members are being seen by civilian physicians. This thesis examines Obstetrical care for active duty servicemembers on the Monterey Peninsula. The central objective of this study was to analyze incentives for civilian Obstetrical/Gynecological physicians to accept active duty patients. To address this issue, interviews were conducted of contracted and non-contracted Obstetrical/Gynecological physicians on the Monterey Peninsula. The interviews obtained information about the physicians' costs and benefits for accepting active duty patients. Additionally, with the payment for an active duty member's medical treatment care being closely liked to Medicare rates, the interview data was compared to studies on barriers to prenatal care for low-income patients. The major findings were that the major disadvantage to accepting active duty patients is not that the military pays for health care at a discounted rate. The major disadvantage for physicians to accept active duty patients is the volume of paperwork and claims filing associated with being a contracted physician. The primary benefit the physicians receive by accepting active duty patients is the additional volume of patients.

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COST-BENEFIT ANALYSIS OF OBSTETRICAL/GYNECOLOGICAL PHYSICIANS WHO ACCEPT ACTIVE DUTY PATIENTS ON THE MONTEREY PENINSULA

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ABSTRACT

With major shifts in military health care, more active duty members are being seen by civilian physicians. This thesis examines Obstetrical care for active duty service members on the Monterey Peninsula. The central objective of this study was to analyze incentives for civilian Obstetrical/Gynecological physicians to accept active duty patients. To address this issue, interviews were conducted of contracted and non-contracted Obstetrical/Gynecological physicians on the Monterey Peninsula. The interviews obtained information about the physicians' costs and benefits for accepting active duty patients. Additionally, with the payment for an active duty member's medical treatment care being closely liked to Medicare rates, the interview data was compared to studies on barriers to prenatal care for low-income patients. The major findings were that the major disadvantage to accepting active duty patients is not that the military pays for health care at a discounted rate. The major disadvantage for physicians to accept active duty patients is the volume of paperwork and claims filing associated with being a contracted physician. The primary benefit the physicians receive by accepting active duty patients is the additional volume of patients.

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I. INTRODUCTION

A. BACKGROUND INFORMATION

Primary care clinics are the first points of contact for active duty service members to receive medical care. The primary care clinic's services include treatment for minor illnesses, routine physical exams, diagnostic services, X-rays, prescriptions and laboratory work. Many specialized services, such as: Obstetrical/Gynecology, Orthopedics, Dermatology, Urology, Podiatry, and Physical Therapy, are not provided at the primary care clinics. For these services, the active duty member is referred out to the nearest military hospital. If the military hospital does not have the facilities to treat the member, or if the closest military hospital is located further than 40 miles away, the member is typically treated by the local private sector contract providers. In some cases, the patient is sent to the next closest capable military hospital.

Before the Silas B. Hays Army Community Hospital in Fort Ord, CA closed, specialized treatments were provided for the active duty and their family members at the Army Hospital with precedence to the active duty members. Since Silas B. Hays Army Hospital closed, all specialized treatments, otherwise provided by a military hospital, are now provided by the local community or provided by the nearest military hospital. The nearest military hospital is located in Oakland, CA which is further than 40 miles from the Monterey Peninsula. In the case of pregnant service members, with the nearest military hospital being more than 40 miles away, the active duty member has the option of using a locally contracted civilian Obstetrical/Gyncological (OB/GYN) physician or using the nearest military hospital. Because Oakland is a long commute, a majority of active duty OB patients elect for a local

physician, as do pregnant active duty family members. Therefore, since the closure of Silas B. Hays Army Community Hospital, the local OB/GYN physicians treat pregnant active duty members and active duty family members who would have otherwise been seen at the military hospital.

B. OBJECTIVES OF THE RESEARCH

Since Silas B. Hays Army Community Hospital closed, active duty military members stationed on the Monterey Peninsula have become reliant on contract civilian OB/GYN physicians. Civilian physicians who accept active duty patients are paid according to Medicare related rates. Historically, Medicare rates have been less than rates paid by other insurance carriers. If the reimbursement rates are too low for physicians to make a profit, then the cost for accepting active duty patients could outweigh the benefit of the additional workload.

To ensure there is sufficient, quality OB/GYN physicians available for pregnant active duty members, understanding local physicians' costs and benefits is essential in establishing an equitable relationship. The research will determine what the marginal costs and benefits are for accepting active duty patients in order to negotiate an equitable arrangement with local civilian physicians.

C. RESEARCH QUESTION

The primary research question of the thesis is: What are the costs and benefits (advantages and disadvantages) to Monterey Peninsula OB/GYN physicians who accept active duty patients?

Subsidiary research questions are:

1. What "profile" of physician is willing to accept active duty patients (i.e., younger, opening a practice on the Monterey Peninsula, prior military service, etc.)?

2. What is the average fee-for-service charged by civilian OB/GYN physicians for a normal delivery on the Monterey Peninsula?

3. What do the local civilian OB/GYN physicians regard as benefits for accepting active duty patients (i.e., healthier patients, increased volume, guaranteed payment, fulfilling a personal moral obligation, etc.)?

4. What percent of a civilian OB/GYN physicians' patients load are active duty patients?

5. What do the local civilian OB/GYN physicians regard as costs for accepting active duty patients (i.e., short-term patients, extra office staff needed to file claims, delayed payment, approvals for extra procedures, fee-for service too low, etc.)?

6. How does the DoD determine the amount paid to civilian physicians for a normal delivery for active duty patients?

7. How much does the Department of Defense (DoD) pay per active duty patient for a normal delivery on the Monterey Peninsula?

8. How does the amount the DoD pays for a normal vaginal delivery compare to other third party payers?

D. SCOPE

This thesis concentrates on civilian OB/GYN physicians' perceived costs and benefits associated with accepting active duty patients. The civilian OB/GYN physicians considered will be only those on the Monterey Peninsula. This thesis does not analyze other locations without a nearby military hospital where contracted OB/GYN physicians are used by the DoD

The costs and benefits may be financial or non-financial. This thesis will not quantify non-financial data. Payment to civilian physicians from other insurance carriers will be discussed in a general sense, but actual figures will not be disclosed due to their proprietary nature. All other proprietary information will be broadly discussed but not specifically disclosed.

The health care industry is dramatically changing. Currently Medicare is under reform as well as the military's health care delivery system. This thesis will be current as of the date of publication but cannot predict changes in the current health care system. This thesis does not analyze the changes in the Medicare program or the Medicare rate structure. Nor does this thesis analyze the current TRICARE program.

E. METHODOLOGY

All seven OB/GYN physicians on the Monterey Peninsula who accepted active duty OB patients prior to December 1, 1995 were asked to participate in an interview. The interview involved questions regarding the physicians' perceived costs and benefits for accepting active duty patients. Costs were considered as any extra expenses incurred by accepting active duty patients. Active duty OB patients on the Monterey Peninsula are only

seen by network providers who are primarily contracted to serve the active duty family members. Therefore the costs of accepting active duty patients include the cost of being a network provider and servicing the active duty family member population in addition to the cost of servicing the active duty population. These costs may include: hiring more office staff, more time filing claims, delayed payments, etc. Benefits were considered as any additional gain physicians receive by accepting active duty patients. Again, since only contracted physicians are eligible to treat active duty patients on the Monterey Peninsula, the benefits associated with being a contracted physician and accepting active duty family members are included in the research. These benefits may include: treating healthy patients, guaranteed payments for services, additional volume, etc.

All non-contracted OB/GYN physicians in Monterey were also asked to participate in a similar interview. However, based on the low volume of active duty OB patients treated in Salinas, the non-contracted OB/GYN physicians in Salinas were not asked for an interview. Non-contracted physicians were asked about their perceived costs and benefits for not becoming a contracted physician and subsequently not accepting active duty patients.

Archival data will be collected from the Civilian Health and Medical Program of the Uniform Services (CHAMPUS) Policy Manual to determine the basis for which the DoD pays civilian physicians. CMAC will be compared to the average fee for service local civilian physicians' charge. This comparison will assess by what factor the DoD pays above or below the local physicians' fee. Physicians' charges are historically higher than the amount that they are reimbursed. Not unless the physicians set their rates at an amount which they expect to get reimbursed do the physicians get the amount that they charge.Therefore, the amount that

the DoD pays local contracted physicians will also be compared to what other third party organizations are paying for the same services. If contracted physicians are willing to accept less from the DoD than from other third party organizations, then either the physician's costs are less than the amount received by other third party organizations or there are additional non-financial benefits which compensate for lower payment.

II. MILITARY HEALTH CARE IN THE MONTEREY REGION

A. OVERVIEW

Chapter II presents the health care delivery system for the active duty military on the Monterey Peninsula. This chapter addresses why active duty military are being seen by civilian physicians. This chapter establishes the need for contractual agreements between the DoD and civilian physicians.

B. SILAS B. HAYS ARMY COMMUNITY HOSPITAL

Prior to closing in 1994, Silas B. Hays Army Community Hospital was the principal health care provider for the military on the Monterey Peninsula. [Fort Ord; pg.5] The hospital primarily serviced military personnel attached to one of three Monterey Peninsula military installations: Fort Ord, the Defense Language Institute located at the Presidio of Monterey, and the Naval Postgraduate School. It provided both inpatient and outpatient services with priority to active duty personnel, and "space available" care to all other DoD beneficiaries: family members of active duty personnel, retirees and retirees' family members.

Silas B. Hays Army Hospital was closed by the DoD and the Base Realignment and Closure (BRAC) Commission in 1991. [Fort Ord; pg. 1] Following the BRAC decision, the Army was directed to find an alternative way to provide for the medical needs of the remaining active duty and their families. Between the time of the BRAC decision in 1991 and the final closure of Silas B. Hays on June 30, 1994, medical services were shifted out of Silas B. Hays. In August 1993, the California Medical Detachment (CMD), Monterey Bay Region, was established to provide health care for the remaining active duty military. [Fort Ord; pg.14]

C. CALIFORNIA MEDICAL DETACHMENT

The California Medical Detachment (CMD) oversees the Army health care delivery system in California and Nevada. Therefore, the CMD is responsible for health care administration at the Presidio of Monterey Army Health Clinic (POMAHC) and contracting for health care services beyond the capability of the POMAHC. The POMAHC is the primary care clinic for active duty members stationed at the Defense Language Institute and the Naval Postgraduate School, which are both located on the Monterey Peninsula.

The primary mission of the CMD is to provide quality health care to active duty service members. Although the CMD is responsible for ensuring outpatient and inpatient care is available for the active duty member, it does not directly provide all the necessary medical care. Inpatient care for the active duty is provided either through the nearest military hospital or through arrangements with local hospitals. Outpatient care for active duty members is provided at the POMAHC and by local civilian specialty providers. The POMAHC offers military physicians and contracted civilian physicians for general medicine and certain specialities of high cost and high use such as: Orthopedic, Podiatry, Flight Medical, Optometry, etc. Other specialized care not offered at the POMAHC, including Obstetrical care, is provided by locally contracted civilian specialty providers.

Although CMD is responsible for contracting for health care services beyond the capability of the POMAHC, CMD uses local civilian specialty providers from the managed care contractor's preferred provider network vice contracting separately for the active duty's outpatient health care needs. The managed care contractor, AETNA, manages the health care programs for active duty family members and retirees as set forth by the Civilian Health and

Medical Program of the Uniform Services (CHAMPUS).

D. CHAMPUS

The Civilian Health and Medical Program of the Uniform Services (CHAMPUS) is designed to meet the health care needs of the active duty family members and retirees and their family members who are under the age of 65. Active duty service members, parents, parents-in-law and pre-adoptive children are ineligible for CHAMPUS.

CHAMPUS shares the cost of civilian provided health care with their beneficiaries. Although CHAMPUS covers most health care that is medically necessary, CHAMPUS has restrictions on which services are covered and the maximum allowable payment for such services.

1. Champus Maximum Allowable Charge

The amount that CHAMPUS authorizes for certain services is called the CHAMPUS Maximum Allowable Charge (CMAC) in the area. CMAC is determined by the lowest of 1) the actual billed charge, 2) the national prevailing charge for a particular procedure adjusted by a local geographic factor, and 3) the maximum allowable prevailing charge established by applying a Medicare Economic Index. [CHAMPUS; Section 1.1; Revision 4; pg. 1.1.1] Consequently, CMAC rates are closely related to Medicare rates. For procedures in which CMAC exceeds the Medicare fee in a given year, CMAC is reduced the following year by the lesser of the amount that CMAC exceeds the Medicare fee, or 15%. Similarly, increases in the Medicare rate are reflected with corresponding increases in CMAC. [CHAMPUS; Section 1.5; Revision 5; pg. 1.5.10]

2. TRICARE

CHAMPUS eligible beneficiaries can choose one of three health care plans: TRICARE STANDARD, TRICARE EXTRA, or TRICARE PRIME. These programs differ in two main areas: the amount of cost sharing done between the beneficiary and CHAMPUS, and choice of physicians.

Both TRICARE EXTRA and TRICARE STANDARD require an annual deductible. Neither requires enrollment and the beneficiary can use either program at any time. A CHAMPUS eligible beneficiary is using TRICARE STANDARD when he or she elects a physician who is not in the network of providers. Therefore, in addition to paying 20% of CMAC for services, he or she must also pay the amount above CMAC to cover the physician's charge up to 115% of CMAC. A CHAMPUS eligible beneficiary is using TRICARE EXTRA when he or she elects to use a network provider. By choosing a network provider, the beneficiaries' cost-share may be reduced from that of CHAMPUS STANDARD.

TRICARE PRIME is the least costly health care option for a CHAMPUS eligible beneficiary. TRICARE PRIME is similar to a Health Maintenance Organization (HMO). The CHAMPUS beneficiary must enroll in TRICARE PRIME and choose a Primary Care Manager (PCM) from the same network of providers used by the TRICARE EXTRA plan. The enrollee pays a minimal co-payment for each medical visit, but no deductibles or cost-sharing. The PCM has the responsibility of providing all medical care to the beneficiary and referring out any treatments which he or she cannot provide.

E. AETNA GOVERNMENT HEALTH PLAN

In January 1994, the Department of Defense selected Aetna Government Health Plan, a subsidiary of Aetna Life & Casualty, as the prime contractor to manage the TRICARE PRIME and EXTRA programs in California and Hawaii. [Office; pg. 32.]As the administrator of the TRICARE PRIME and EXTRA programs, AETNA's responsibilities include contracting and negotiating fees with civilian physicians, educating the beneficiaries and civilian providers, and ensuring beneficiaries receive quality health care. [Nolin; interview]

AETNA markets local physicians who then submit applications for admittance into the preferred provider network. Physicians are accepted into the preferred provider network based on factors such as: CHAMPUS accredited schooling, acceptable malpractice rates, and adequate insurance coverage. Aetna negotiates fees separately with each network provider. Aetna works to negotiate fees below the CMAC rate, thus providing a savings to the government.

Even though active duty members are ineligible for the TRICARE program, the contract between the DoD and Aetna allows for the active duty service member to utilize the preferred providers. The active duty member, however, is not responsible for any deductible, cost-sharing or co-payment. The CMD pays for the active duty member's outpatient medical services at the discount CMAC rate negotiated by Aetna.

III. METHODOLOGY

A. SOURCES OF DATA

This thesis uses two primary sources of data: interview and archival. Interview data was collected from OB/GYN physicians and their office managers on the Monterey Peninsula. The physicians provided non-financial data while the office managers provided financial data. Archival data was collected from active duty obstetrical patients' records, hospital records, GAO reports, and previous studies regarding physicians' incentives for accepting low paying patients.

B. INTERVIEW SELECTION

On December 1, 1995, AETNA had contracts with eight OB/GYN physicians located on the Monterey Peninsula in the cities of Monterey and Salinas. Four OB/GYN physicians practiced in Monterey and the remaining four OB/GYN physicians practiced in Salinas. The two military installations on the Monterey Peninsula, DLI and NPS, are located in the city of Monterey. Salinas, on the other hand, is located approximately 20 miles northeast of Monterey and does not have a military installation. Although all of the pregnant service members are stationed in Monterey, some service members choose to use network OB/GYN physicians in Salinas.

All network OB/GYN physicians in Monterey and Salinas were asked to participate in an interview. An initial screening of all pregnant active duty members in 1995, who were stationed at either DLI or NPS, revealed that 97% (76 out of 78 in 1995) of the pregnant active duty members were seen by OB/GYN network providers in Monterey. Since this initial

survey indicated the active duty preference to be seen in Monterey, all OB/GYN physicians (network providers and non-network providers) in Monterey were asked to participate in an interview. Even though Monterey and Salinas each offer four network providers, only 2.5% (two of 78) of the pregnant active duty patients elected to been seen in Salinas in 1995. Coincidentally, both of these active duty patients were seen by the same physician. Interviews with several military family members and active duty members indicate that their preference to be treated in Monterey is based on the driving time to Salinas. Based on the low volume of active duty OB patients treated in Salinas, the Salinas non-network providers were not part of the interview process.

Interviews from the network providers yields direct information regarding costs and benefits to civilian physicians who accept active duty patients. Interviews from the non-network providers yield indirect information regarding the costs and benefits to civilian providers who accept active duty patients.

1. Network Providers

On the Monterey Peninsula, there are eight network providers: four in Monterey and four in Salinas. The Monterey network providers are Drs. Alexander, Keith, Vogelpohl, and Walker which are grouped into three practices. Drs. Keith and Vogelpohl are in practice together. Dr. Walker has his own practice and occupies an office below Drs. Keith and Vogelpohl. All of the network providers in Monterey agreed to participate in the interview except for Dr. Alexander.

The Salinas network providers are Drs. Perron, Goodwein, Yaqub, and Ramirez which are grouped into two practices. Dr. Perron does not have her own practice since she

is an employee of Natividad Medical Center, the county hospital. Dr. Perron was not asked to participate in an interview since she does not have her own practice. Drs. Goodwein and Yaqub are in practice together and declined participation in an interview. Dr. Ramirez opened his private practice in July 1994 after an Early Termination of Service (ETS) from the Army. Dr. Ramirez served as an OB/GYN for the Army for fifteen years and his obligation of service ended in 1994. Dr. Ramirez was stationed at Fort Ord prior to leaving the Army. In total, the Monterey Peninsula has eight network OB/GYN providers in five practices: three in Monterey and two in Salinas.

2. Non-network Providers

In Monterey, there are eight non-network providers (four practices): Drs. Adams, Lee, Pretzer, Hanson, Taylor, Rydell, Eandi, and Fuestner. Drs. Adams, Lee, and Pretzer are in practice together, and Drs. Rydell, Eandi, and Fuestner are in practice together. Drs. Hanson and Taylor while not in practice together, occupy offices adjacent to each other and cover each other's patients every other weekend. All four non-network practices in Monterey were asked to participate in an interview.

Drs. Hanson and Taylor are the only two female obstetrical physicians in Monterey. Both Drs. Hanson and Taylor have applied to be network providers. Dr. Hanson is awaiting her reply while Dr. Taylor's application was declined by AETNA. Dr. Taylor did not want to be interviewed in light of her status with AETNA. Dr. Rydell agreed to be interviewed as a representative for his practice. All of the non-network providers' office managers agreed to a phone interview.

C. INTERVIEW DATA

Interview data reveals both financial costs and non-financial costs and benefits for accepting active duty. Physicians provided the non-financial data while their office manager provided the financial data.

Practices were initially contacted by telephone to schedule interviews. Five practices (three network and two non-network practices) agreed to interviews. The remaining parties were sent a follow-up letter (Appendix B and C) encouraging their participation. Enclosed with the letter was a copy of the thesis proposal and a questionnaire. Physicians who returned the questionnaire indicating their willingness to participate were then asked for an interview. All unreturned questionnaires were followed with a telephone call to determine the physician's intent to participate.

Office managers who agreed to participate were given a questionnaire (Appendix D) and then interviewed for further questions. Questions regarding reimbursement rates from insurance carriers are proprietary and not disclosed. Office managers were reluctant to disclose information regarding the practices' monthly expenses.

Interview questions were selected and tailored based on physicians' economic incentives for physicians to accept low paying patients. Active duty patients are low paying patients, however, they are ineligible to participate in low-income medical programs such as Medicare and Medi-Cal. However, the contracted physicians who accept active duty patients are reimbursed at Medicare related rates.Questions were structured to capture marginal costs and marginal benefits for accepting payment at an amount less than other third party payers. Due to the unique nature of active duty patients, who are ineligible for Medicare, being

eligible for medical care at Medicare rates, there is limited research on active duty patients' medical referral into the civilian sector. Therefore, interview questions were not rigidly structured in order to generate an opportunity to explore providers' incentives for accepting this unique pool of patients.

D. ARCHIVAL DATA

Archival data was collected from service members' records with estimated delivery dates in 1995. The records revealed information on active duty delivery rates per physician and active duty transfer rates per physician. The active duty transfer rate is the number of active duty members per month who relocated during their pregnancy due to a permanent change in station or end in obligation of service. Previous studies on barriers to low-income women for pre-natal care revealed data on physicians' incentives for accepting patients whose payments for OB care are less than other third party payers. Data was also collected from studies on increasing Medicaid rates to encourage physicians to accept Medicaid patients. Although the DoD uses a Medicare related fee schedule, and not Medicaid, to pay civilian physicians, data on Medicaid rates are relevant to this thesis. Both Medicare and Medicaid pay less than other insurance carriers. In general, private insurance carriers' allowed charges usually exceed Medicare allowed charges by more than 10%. (GAO Report; pg. 11)

IV. PHYSICIANS COSTS AND BENEFITS

A. OVERVIEW

This chapter describes common characteristics of physicians' practices for Obstetrical physicians who are willing to accept active duty patients. This chapter then outlines OB/GYN physicians' costs and benefits for accepting active duty patients. This chapter does not reflect data from those practices who did not agree to an interview.

B. PHYSICIANS' PROFILES

There are three distinct differences between physicians who were willing to accept active duty patients and those who did not accept active duty patients prior to December 1995. The OB/GYN physician who was willing to accept active duty patients has: 1) a lower than average number of years in Monterey, 2) lower fees for services, and 3) higher number of deliveries per month in comparison to the physician who did not accept active duty patients. Data showed that those physicians who were willing to accept active duty patients but were declined by AETNA have the same practice patterns as the network physicians. Therefore there is a strong correlation between the practice patterns of physicians who are willing to accept active duty patients and network providers who do accept active duty patients.

1. Years in Practice

Differences in years of practice between network OB/GYN providers and non-network providers is illustrated in Figure 1. Three of the four network providers have practiced in Monterey their entire careers as have all the non-network providers. The fourth network provider practiced for eleven years prior to coming to Monterey.

A Monterey network provider averages 10.5 years in practice with 7.75 years being in Monterey. In contrast, a non-network provider averages 18.5 years of practice, all of which was served in Monterey. Dr. Taylor, a non-network provider who has only been in practice for six years, skews the average number of years a non-network provider has been in practice. Dr. Taylor is willing to accept active duty patients but was declined by AETNA. The average non-network provider has 9.5 more years of practice than the average network providers. The OB/GYN physicians with practices younger than 10 years are more willing to accept active duty patients than physicians in older practices.

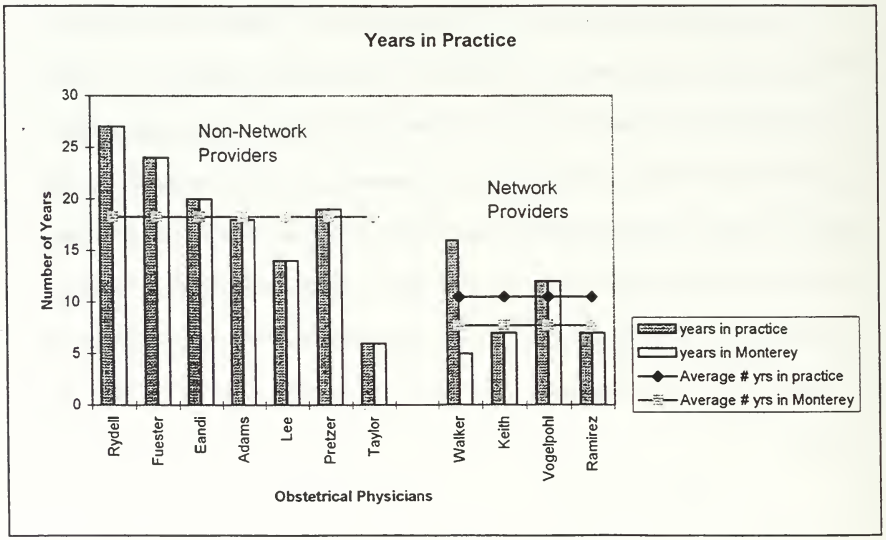

FIGURE 1

2. Fee-for-service

The financial data compares physicians' fees-for-service to the payment from third party payers including the DoD. This data, captured in Figure 2, represents data from all interviewed physicians on the Monterey Peninsula.

a. Global Fee

Physicians charge and are paid on a fee-for-service based on procedural codes listed in Physician's Current and Procedural Terminology, Forth Edition, CPT-4. All physicians and third party payers use the CPT-4 codes to identify individual and package services. The codes specify which services are and are not included with each code. For maternity care, procedure code 59400 identifies an all-inclusive, global normal vaginal delivery. Procedural code 59400 includes routine prenatal office visits, uncomplicated normal vaginal delivery, and post-partum care through six weeks. The global fee does not include any complication which may arise during the prenatal or post-partum period and/or delivery, laboratory work (pap, urine, blood tests, etc.), medications, circumcisions, anesthesia at delivery, or an ultrasound examination. A separate billing code is made for any complication or any additional medical care not covered in the global fee [CHAMPUS; Chapter III; section 3.8; pp. 3.8.1-3.8.5].

Each physician establishes their own fee-for-service for each CPT-4 code. For a normal vaginal delivery in the Monterey Peninsula the fee-for-service varies from $1800 to $2200. Figure 2 displays the difference in the fee-for service for network providers and non-network providers.

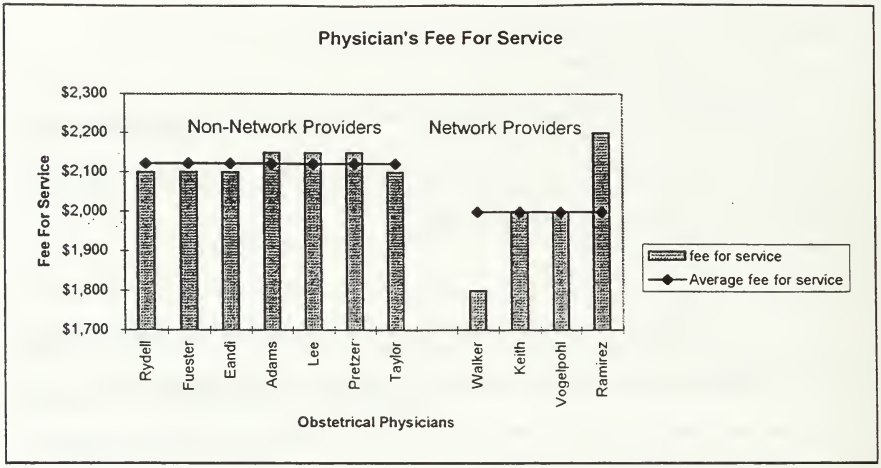

FIGURE 2

b. Reimbursement for Services

As illustrated in Figure 2, the fee-for-service for non-network providers is higher than for network providers. The average fee-for-service for network providers is $2000 while the average fee-for-service for non-network providers is $2117. The network providers charge $117 less than non-network providers for the same CPT-4 code.

Figure 2 only illustrates the physicians' fees-for-service. It does not indicate the actual amount each physician receives for CPT-4 code 59400. Each third party payer, such as CHAMPUS, sets limitations on the amount reimbursable for each CPT-4 code. CHAMPUS refers to its maximum allowable fee as CMAC (see Chapter 2). The physicians' fees for service are the maximum amount billed to the third party payer for each code. The

physician receives no more than their fee-for-service and may even have agreed to accept an amount less than their fee-for-service from the third party payers.

The amount physicians are paid by insurance companies for the same procedural code varies widely. Physicians accept payment from PPO's, HMO's, the military, and Medi-Cal. The actual amounts that physicians have contracted with the insurance companies are proprietary information. However, the physicians agreed that PPO's paid the closest to the fee-for-service, with HMOs, the military, and Medi-Cal trailing behind. Physicians and office managers stated that Medi-Cal pays $967.20 for procedural code 59400. [Hardy, Lagle, and Taylor] (Medi-Cal's payment is not proprietary) Medi-Cal pays less than half of the average fee-for-service for network providers (48% of $2000) and 46% of the average fee-for-service for non-network providers.

The amount that the military pays physicians is based on the individual contract that AETNA negotiated with the physician. AETNA strives to negotiate fees less than the CMAC rate. CMAC rates, as stated in Chapter II, are based on a Medicare related formula. Historical data shows that Medicare's maximum allowed charges are at least 10% below other private insurance carriers' allowed charges. (GAO Report; pg. 11) Therefore, with Medicare being 10% below other private insurance carriers, CMAC is also below other insurance carriers. Moreover, contract network physicians are willing to accept less than CMAC for their services, thereby accepting even less than other third party payers. In order to accept a lower fee-for-service, a network provider must have lower expenses or a higher volume of patients than a non-network provider.

3. Patient Volume

The number of deliveries per month per physician varies widely, as illustrated in Figure 3. The data reflects the average number of deliveries per month in 1995. The network providers have a higher delivery rate than non-network providers. This can be explained by differences in physicians' decisions to accept an additional workload and the decision to have a practice with another physician.

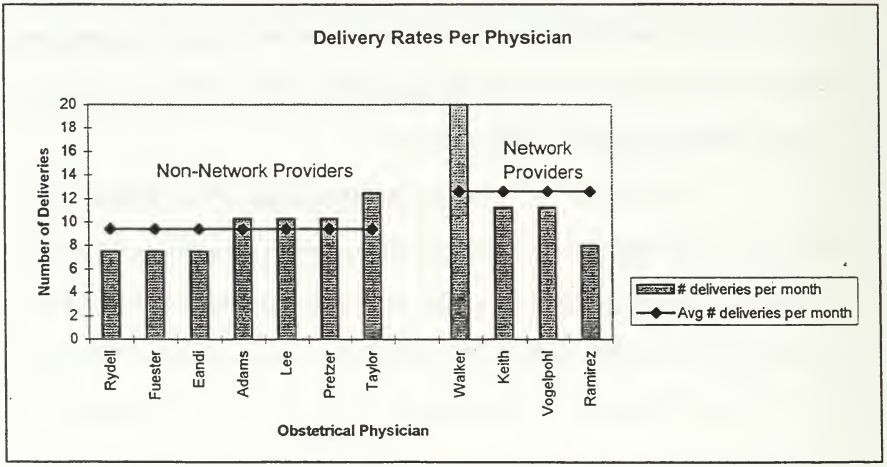

FIGURE 3

All network providers interviewed stated that they accepted active duty patients primarily to increase their patient load. [Walker, Keith, Ramirez] Dr. Walker, since his arrival in Monterey, has actively sought to expand his practice.[Walker] He continues to lead the other area physicians in the number of deliveries per month. Dr. Walker delivered an average of 20 babies per month. Dr. Taylor has the next highest delivery rate of 12.5 patients per month. Dr. Walker's delivery rate exceeded Dr. Taylor's delivery rate by 60%. The average number of deliveries for a network provider is 12.625 babies. Dr. Walker exceeds the average number of network deliveries by 58%. The average number of deliveries per month for non-network providers is 9.43 per month. The average number of deliveries for network providers exceeds the number of non-network providers by 25%.

Dr. Walker's data may seem to be an outlier. However, he is the only single practice network provider who agreed to participate in an interview. Dr. Alexander also maintains his own practice, yet did not agree to an interview. Without another single practice network providers' data to compare to Dr. Walker's, Dr. Walker's data should not be considered as an outlier.

A sampling of all active duty OB patients with estimated delivery dates in 1995 yielded a noticeable difference in the number of active duty patients each network physician accepted, as illustrated in Figure 4. Of the 78 active duty patients with estimated delivery dates in 1995, Drs. Keith/ Vogelpohl and Walker combined practices accounted for 89% (69 of the 78) of the active duty OB patients. Drs. Keith and Vogelpohl's practice accepted 53% (41 of the 78) while Dr. Walker accepted 36% (28 of the 78) of the active duty OB patients.

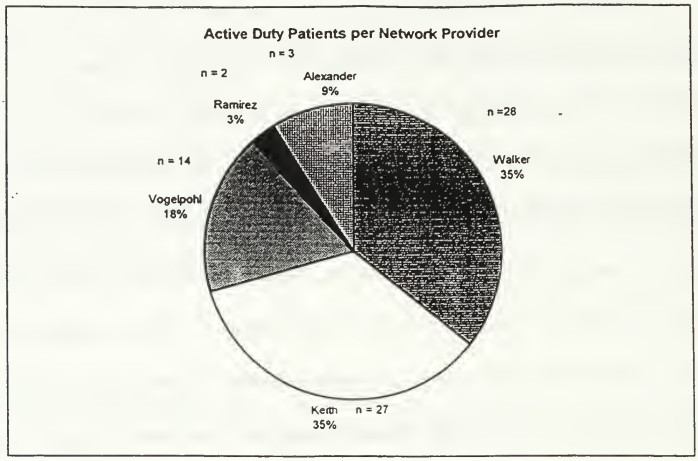

FIGURE 4

Individually, Dr. Keith accepted 27 active duty patients and Dr. Vogelpohl accepted 14. Drs. Keith and Vogelpohl averaged 20.5 active duty patients while Dr. Walker accepted 28.

Drs. Keith and Walker have the highest active duty delivery rates with 15 and 13 deliveries, respectfully, from active duty patients, as illustrated in Figure 5. Dr. Vogelpohl, who is in practice with Dr. Keith, delivered 8 babies for active duty patients. Drs. Alexander and Ramirez were the lowest with 3 and 2 deliveries, respectively. Figure 4 being the number of active duty women accepted as patients is slightly different than Figure 5 which is number of actual number of deliveries. The number in Figure 4 are higher than those in Figure 5 due to some active duty patients not caring their babies to full-term or transferring out of the area

prior to delivery.

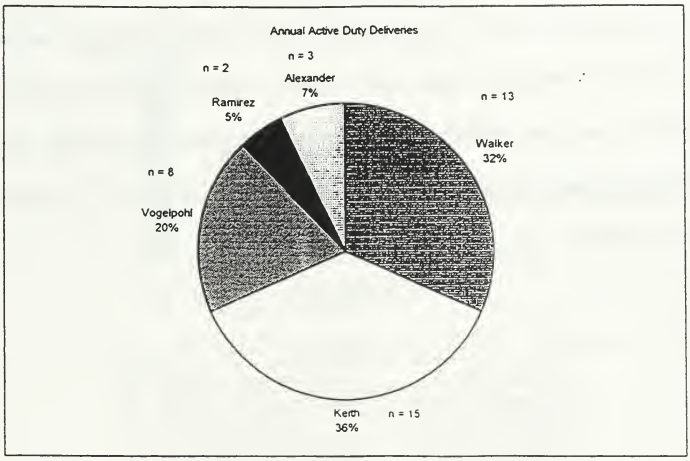

FIGURE 5

Doctors who are in practice together are able to realize economies of scale by pooling their office staff and space. For example, network providers, Drs. Keith and Vogelpohl, who are in practice together, do not individually need to deliver as many babies as Dr Walker, who occupies a similar office space located below Drs. Keith and Vogelpohl. Non-network providers also realize economies of scale. Drs. Rydell, Eandi, and Fuestner occupy an office in the same complex as Drs. Keith, Vogelpohl, and Walker. While Drs. Rydell, Eandi, and Fuestner occupy a large office space than either Drs. Keith/Vogelpohl or Dr. Walker, they have a single office manager and the same number of office staff as Drs. Keith and Vogelpohl.

C. PHYSICIANS' BENEFITS

The decision to accept or not to accept pregnant active duty patients depends upon several variables. When asked about the benefits of accepting active duty patients the physicians' responses were generally consistent with one another. The physicians' responses to what they consider to be advantages or benefits for accepting active duty patients are captured in Table 1.

TABLE 1

	Response
Volume increase	100% of network providers
Guaranteed payment	100% of network providers
CMD timely payment	75% of network providers
Healthy patients	67% of network providers
Responsible patients	25% of network providers
Civic obligation	25% of network providers

Unanimously, all network physicians agreed the primary reason for accepting active duty patients was to increase their patient load. Their primary decision to become a network provider was to increase their workload by accepting active duty family members. Treating active duty members was not initially in the physicians' contract with AETNA. However, the network physicians willingly agreed to accept active duty patients when the opportunity arose. Active duty family members contribute to 20% to 30% of a network providers' patient load, whereas the active duty contribute 2% to 5% of the network providers workload, as illustrated in Figure 6.

Most network providers were able to accept the additional patients without hiring

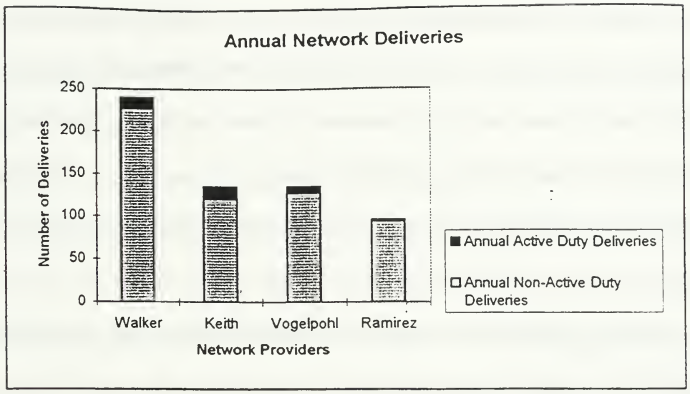

FIGURE 6

additional office staff. In other words, the physicians were able to accept the additional patients without incurring additional overhead. Therefore, the additional workload contributed to the physicians' profit margin. Dr. Ramirez was the only network provider who hired a biller specifically for military claims. All other network providers undertook the additional patient load with unnoticeable affects on the staff's workload.

Secondary benefits were both financial and non-financial. In comparison to other forms of payment to physicians, the physician does not receive any payment from the active duty member. CMD pays the full negotiated fee to the physician. Other insurance carriers typically send payments to the patient with instruction to then pay the physician. In TRICARE programs, the active duty family member pays a co-payment to the physician. In contrast, active duty patients do not make any payments to the physicians; CMD pays the physicians directly in the full negotiated amount. Therefore, the physician is guaranteed payment and does not have an account for receivables from active duty patients.

Of the network physicians interviewed, 75% stated that CMD pays promptly. Office managers stated that CMD paid typically within four to six weeks of being billed. [Hardy, Keith's] Other insurance carriers take between two weeks and 90 days. The shortest payers are those who use electronic filing payments. They typically pay in two to three weeks. The longer payers are those with more than a one stop process. These typically pay in 60 to 90 days.

Physicians stated several non-financial benefits for accepting active duty patients. Of the OB/GYN physicians interviewed, 67% thought that active duty patients were in excellent health without many health risks. Active duty patients are also seen as being stable, educated, mature, and responsible. Physicians felt that these four characteristics (stability, education, maturity, and responsibility) made patients more attentive to taking their medication, adhering to their physician's advice, and not requiring extra time during an office visit to re-explain information.

The network physicians' statements regarding their desire to accept healthy, responsible patients is reinforced by a study on prenatal care for Medi-Cal patients. These patients are typically not as healthy or responsible. This study concluded that physicians are reluctant to accept Medi-Cal patients because they are less compliant with keeping appointments and following physicians' instructions. They are also more likely to file a lawsuit and be substance abusers. This study also concluded that physicians are reluctant to treat Medi-Cal patients because of cultural and social economic differences and patients' personal hygiene habits. [Aved]

Although low in response rate, another non-financial benefit for accepting active duty

patients is a sense of civic obligation. Dr. Ramirez, who served 15 years as a military officer, expressed his desire to accept active duty patient because of a sense of duty to his fellow officers. [Ramirez]

D. COSTS

When asked about the disadvantages or costs of accepting active duty patients, physicians' answers were consistent with one another. Non-network providers were more inclined to discuss costs than the benefits for accepting active duty. For them, the costs for accepting active duty outweighs the benefit. Table 2 outlines physicians' responses to disadvantages or costs for accepting active duty patients.

TABLE 2

	Response
Volume of paperwork	50% of network and 100 % non-network providers
Pre-authorization	50% of network and 50% of non-network providers
Short-term patients	75% of network providers
Require hiring staff	25% of network providers
Low payment	25% of network providers

The primary reason non-network providers do not accept military patients is the volume of paperwork associated with being a network provider. A physician must first be a network provider in order to be eligible to treat active duty OB patients on the Monterey Peninsula. Therefore, the physician must first be willing to accept TRICARE Prime and its associated volume of paperwork to file each claim. Although the volume of paperwork is minimal for active duty patients, the paperwork associated with the TRICARE program is the largest deterrent for accepting military patients. If the physician is unwilling to accept TRICARE Prime and its accompanying paperwork, the physician is then ineligible to treat

active duty patients.

The second largest reason for not accepting active duty patients is the amount of time the physicians' office staff spends trying to get pre-approvals for various treatment. Since any complication or medical treatment outside of Procedural code 59400 is billed separately, the physician must be granted prior approval from CMD any time a complication or separate medical treatment is needed. Although pre-approvals are required for any treatment from all insurance carriers, the physicians believed that it is more difficult to get pre-approvals through CMD and TRICARE than their other insurance carriers.

The next significant cost for accepting active duty patients is the fact that they are short-term patients. Active duty OB patients are only patients of civilian practitioners during their gestation period. After the six-week post-partum check-up, the active duty members return to the POMAHC for any gynecological treatment rather than continue as a civilian practitioners' patient. Other non-military patients and active duty family members are able to continue gynecological (GYN) care with the physician giving the physician a stable pool of GYN patients. If the active duty OB patients were to continue their care with civilian practitioner after their delivery, the physicians' GYN pool would be larger.

In addition to not being able to continue as a GYN patient after delivery, the active duty OB patients frequently transfer to another location during the gestation period. According to records of active duty patients with estimated delivery dates in 1995, 35% of the active duty OB patients transferred to another location during their pregnancy. When patients transfer to another location before their delivery date, the physicians are paid according to the number of prenatal visits the patient has received. There is insufficient data

to determine the percentage of pregnant active duty patients who transfer into the Monterey Peninsula to determine if the OB/GYN physicians are gaining as many patients as they are losing in a given month.

The remaining two costs for accepting active duty patients are too little payment and having to hire additional staff. These two cost concerns were from Dr. Ramirez who began his civilian practice in June 1994. His initial clientele was primary military patients. In his initial year in practice, he had a high volume of TRICARE Prime patients and not many civilian patients. The volume of TRICARE patients from other third party payers was not high enough to balance the amount he received from AETNA. Dr. Ramirez's combination of a high volume of military patients and being new civilian practitioner led him to hiring an additional biller for military claims.

A study on increasing Medicaid and its effect on prenatal care availablility proved that a moderate rise in the fee increased overall physicians' willingness to treat this low-income population. However, the study suggested that raising the Medicaid rates to the level of private third party payers does not in itself guarantee physicians' willingness to treat this low income population. [Fox M.H.] Therefore, although Dr. Ramirez claim of low payment may be true, raising the rates AETNA negotiates with the physician to equal that of other third party payers may not guarantee that other physicians would be willing to accept active duty patients.

V. CONCLUSIONS AND RECOMMENDATIONS

A. CONCLUSIONS

The purpose of this thesis was to provide a cost and benefit analysis of Obstetrical/Gynecological physicians on the Monterey Peninsula who accept active duty patients. By interviewing network and non-network OB/GYN physicians in Monterey and Salinas, data was collected to asses their perceived costs and benefits. The interview data was compared to previous studies conducted regarding physicians reasons for not accepting Medi-Cal patients. Archival data was collected from active duty patients' records to confirm physicians' patient load and active duty patients' transfer rates. The data collected answered the research questions regarding physicians costs and benefits.

1. Network Physician Profile

There are three distinct characteristics of physicians who are willing to accept active duty patients. Obstetrical physicians who are willing to become network providers have a newer practice, lower fee-for-service, and higher delivery rates. Network physicians accept military and active duty patients in order to expand their newer practices. They are willing to set their fees-for-services lower and deliver more babies than non-network providers. A network provider averages $2000 for a normal vaginal delivery, while a non-network provider averages $2117. Although physicians are rarely reimbursed at their full fee-for-service, by setting a lower fee-for-service, the maximum reimbursement for network providers is lower than for non-network providers. A network provider's delivery rates are 25 % higher than non-network provider delivery rates. The active duty make-up 2% to 5% of the network provider volume.

2. Benefits

The active duty population represents a healthy population with low risk pregnancies and minimal office time requirements. Although these patients may not pay fees as high as other insurance carriers, there are advantages to accepting them as patients.

The interviewed physicians perceive several benefits from accepting active duty patients. By being network providers, physicians increase their patient load and thereby increase their profit margin. Most physicians were able to carry the additional patient load with unnoticeable affects on their staffs' workload. In the case of new physicians, it cannot be measured if the additional military patients present any real additional workload since they have not learned to become efficient and streamline their practices.

The active duty patients were considered to be typically healthier and have lower risk pregnancies than other patients. These benefits in addition to active duty patients being seen as stable, mature, educated and more compliant in comparison to other paitents, make the active duty patients desireable.

Besides the health and overall welfare of the active duty patients, there are financial benefits associated with payment from the California Medical Detachment (CMD). Physicians noted that in comparison to TRICARE and other third party payers, CMD pays in a timely manner. CMD is not the fastest payer nor are they the slowest. The fastest payers are those insurance carriers whose claims are filed electronically. Secondly, when an active duty patient is treated, the physician is guaranteed to be paid since CMD sends the full negotiated fee directly to the physician. Since there is no co-payment from the active duty member and the payment is sent directly to the physician, the physician is guaranteed payment. For physicians

with prior military serve, they may also perceive accepting active duty patients as fulfillment of a civic obligation.

3. Costs

The most significant cost associated with accepting active duty patients is related to having to accept TRICARE Prime. Pregnant active duty members are only serviced by network OB/GYN physicians. These network physicians who accept active duty also accept TRICARE Prime patients. Providers perceive a larger volume of paperwork with filing TRICARE Prime claims in addition to the more difficulty getting pre-approvals than other carriers. Therefore, if a physician wants to treat active duty patients, he must be willing to overcome the paperwork issue associated with being a network provider, even though the paperwork is actually less for active duty claims than it is for active duty family members.

The findings of this study does not entirely support the cost of hiring more office staff to accommodate the additional workload. An additional staff members are required if the provider is at "capacity"; however, it may also may reflect that the provider is still learning business operations in the civilian community. Other network OB/GYN physicians whose practices were more established were able to undertake the additional workload without incurring any noticeable change in their monthly expeditures.

The disadvantage of accepting active duty patients due to their low reimbursement rate is unfounded. DoD uses CMAC to determine how much to pay for medical services. CMAC is determined by using a Medicare related formula. Historically, Medicare has paid physicians 10% less than other third party providers. In each contractual arrangement with the network physician. the network physician negotiates a reimbursement fee with AETNA.

AETNA strives to negotiate a fee less than CMAC with each physician. Therefore, network physicians are willing to accept a discount from an already reduced payment. Physicians are willing to accept this discounted fee when their volume is high enough to support their costs.

B. RECOMMENDATIONS

In a contractual arrangement, both parties need to understand each others costs and benefits to establish an equitable agreement. The physicians' monthly operational expenses are mostly fixed costs. These fixed costs are not allocated to services that the physician provides. In determining how much it actually "costs" to provide pre-natal care, the physician could allocate his or her fixed costs based on amount of time spent providing such care. This would give the physician a better idea of how much time is spent in each activity and how much each service costs to deliver. Therefore, when going into a negotiation with a network or HMO, or PPO, the physician has better knowledge of his or her costs and can better determine the price of the contract.

Physicians who pool their resources recognize economies of scale. This reduces their per patient costs and may allow them to handle more patients. Furthermore, if the physicians networked amongst themselves as an organization, then when entering into negotiation, the physicians could present a united network when negotiating with insurance carriers.

Having to be a network provider appears to be the primary barrier for physicians not accepting active duty patients. The largest disadvantage for accepting active duty patients is the primary requirement of being a network provider and accepting TRICARE Prime. Physicians perceive the paperwork load for TRICARE Prime patients to be more than that of other third party payers. TRICARE offers electronic billing to their providers. Many

physicians have spent the money to purchase the software which would reduce their paperwork.

In order to justify the amount of paperwork required to file a TRICARE claim as compared to other insurance carriers, further study should be conducted to determine exactly how many forms are required by each third party payer and how long these forms take to fill out. Only by determining and output measure can the DoD know exactly how effective their electronic filing system works. Future studies need to be conducted to determine why more practices are not using the electronic filing system.

APPENDIX A

MISSION STATEMENT OF THE

CALIFORNIA MEDICAL DETACHMENT,

MONTEREY BAY REGION

1. Mission

- For Active Duty Military

  -- Provide Primary Outpatient and Preventative Health Care

  -- Coordinate/Contract Specialty Outpatient Health Care

  -- Coordinate Inpatient Health Care

- For Department of Army/DOD Civilians

  -- Provide AR 40-5/DOD Equivalent Occupational Medicine Support

- For Active Duty Family Members and Retirees

  -- Assist in Health Care Coordination with TRICARE Managed Care Support Program Contractor (AETNA) and/or MEDICARE Program Representatives

2. Support Area:

- Presidio Monterey/Naval Postgraduate School
- Fort Hunter Liggett/Camp Roberts
- Sierra Army Depot

- Hawthorne Army Depot
- Oakland Army Base
- Presidio San Francisco
- Sharp/Tracy Army Depots (Environmental Health Only)
- Camp Parks (Environmental Health Only)

3. Functional Element Guidance: Each CMD Clinic establishes defined managed care tracks with its local civilian health care system and its nearest regional DOD or VA inpatient hospital facility to achieve the best mix of access to cost-effective, quality health care. Consequently, each CMD clinic develops local policies and procedures regarding the following areas:

- Active Duty Outpatient Care (e.g., sick call, routine appointments, specialty care management and referrals, urgent/emergent care, etc.)

- Active Duty Inpatient Care (e.g., referral procedures to local hospital/convalescent center for stabilization/overnight observation, nearest military or VA hospital, how and when to transfer, etc.)

- Family Member of Active Duty Outpatient Care (e.g., interaction with TRICARE Service Center, Resource Sharing/Cooperative Care, management of space available appointments, extent of pharmacy services, etc.)

- Family Member of Active Duty Inpatient Care (TRICARE) Service Center/Hospital Network, availability at DOD hospital facility, etc.)

- Retiree Outpatient Care (see Family Member above)

- Retiree Inpatient Care (see Family Member above)

- Evacuation Policies (duty hour and non-duty hour, ground and air, etc.)

- Emergency Preparedness Plan/Alert Rosters

APPENDIX B

LETTER TO OB/GYN PHYSICIANS ACCEPTING ACTIVE DUTY PATIENTS

Dr. OB/GYN Physician,

With the continual downsizing of the military and fewer military hospitals being available for OB care, these services must be farmed out to the local community. Therefore this places you in a position of substantial power. The military must seek treatment from you because there are no local military physicians. We, the active duty military, are fortunate to have someone such as yourself who is willing to accept us as patients. Several of your military patients have commented to me about your genuine concern for their overall health, prenatal and post-natal care.

I am interested in what you gain and lose by accepting military patients. Surely with the volume of other patients you have (HMO, PPO, etc.), you have little time to deliver other patients. Perhaps, by accepting military patients, you might not be able to accept other patients - just be the shear volume of military patients.

I want to understand your incentives for accepting active duty and dependent military patients. Why would someone such as yourself be willing to accept military patients who pay less than most other providers and require an abundant amount of paperwork? My thesis addresses your costs and benefits for accepting military patients. I have enclosed a small list of questions which will address this issue. I have also enclosed a copy of my thesis proposal so that you might completely understand the emphasis of my research. In the time that it took you to read this letter you could answer the enclosed questions. Even if you do not read the enclosed thesis proposal (which you may keep to read at your discretion), please take a few minutes to review and answer the enclosed questionnaire.

Very Respectfully,

Tracy Butterfield

Background Questions:

1. How many years have you been in practice?

2. How many years have you practiced in Monterey?

3. How long have you accepted military?

Research Questions:

1. How has your volume of military patients changed from 1993 -1995? (Since the closure of Silas B. Hays at Fort Ord - an Army Military Treatment Facility)

2. In this period of time, how has the mix of your other client changed?

3. What benefits do you gain by accepting military patients? (i.e. healthy clients, volume, etc.)

4 Which benefits, if any, are different for active duty patients versus dependent?

5. What non-financial costs do you incur by accepting active duty?

6. What non-financial costs do you incur by accepting dependent military?

7. What could the DoD that would cause you to increase/decrease the number of military patients you accept?

APPENDIX C

LETTER TO OB/GYN PHYSICIANS

NOT ACCEPTING ACTIVE DUTY PATIENTS

Dr. OB/GYN Physician,

With the continual downsizing of the military and fewer military hospitals being available for OB care, these services must be farmed out to the local community. Therefore this places you in a position of substantial power. The military must seek treatment from you because there are no local military physicians.

I am interested in what you gain and lose by not accepting military patients. I want to understand your incentives in deciding your mix of patients. I have already interviewed physicians who do accept military clients. The information from your office will additionally address any costs and benefits that are disincentives for accepting active duty and dependent military patients.

My thesis addresses costs and benefits to civilian physicians for accepting military patients. I have enclosed a small list of questions which will address this issue. I have also enclosed a copy of my thesis proposal so that you might completely understand the emphasis of my research. In the time that it took you to read this letter you could answer the enclosed questions. Even if you do not read the enclosed thesis proposal (which you may keep to read a your discretion), please take a few minutes to review and answer the enclosed questionnaire.

Very Respectfully,

Tracy Butterfield

APPENDIX D

LETTER TO OFFICE MANAGERS

The overall thesis question is, "What are the costs and benefits to civilian physicians for accepting active duty patients". These costs and benefits are both financial and non-financial These questions are designed to determine the physician's financial costs and benefits. Please feel free to add any comments that you feel may help me understand how your office operates.

On average, how many OB patients do you have in each category in a given year:

Active duty ____?

Dependent Military ____?

HMO ___?

PPO ____ ?

Other ____?

What are you average reimbursement rates for OB/prenatal care from each of these categories:

Active duty _____ ?

Dependent Military _____?

HMO _____?

PPO _____ ?

Other _____?

How quickly do these patients/ insurance plans reimburse your office for their services? Are some of them pay as you go?

Active duty _____ ?

Dependent Military _____?

HMO _____?

PPO _____ ?

Other _____?

Does you office allocate expenses based on some causal relationship (i.e. type of treatment, time in office, etc.)?

What is your monthly overhead? How much of this is a fixed cost (does not vary monthly) and how much is variable (changes per patient or per physician)?

If you had any write-offs in the past year, how much of it is attributable to military patients?

Are there financial benefits to your office for accepting military patients other than guaranteed payment for services?

Thank you for your time. I look forward to our interview.

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Interview between K. Hardy, Dr. Walker's officer manager, and author, 25 October 1995.

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Interview between C. Lagle, RNP, Dr. Ramirez's office manager, and author October 3, 1995.

Interview between A. Nolin, AETNA Regional Director for California, and author, 11 January 1996.

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Interview between N. Evans, Dr. S.Taylor's office manager, and author, 31 October 1995.

Interview between S.Walker, MD OB/GYN, and author, October 18,1995.

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